

Ethics briefings

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A right to treatment?

There is growing international debate about the so-called "right to health" and the likely content of such a right as it is gradually defined by international bodies such as the UN committee on economic, social, and cultural rights. Although some countries, such as Mexico, have incorporated the right of access to basic treatment into their national constitution, practical implications generally remain to be fully articulated. Lawyers have been trying to do this by developing internationally accepted indicators which can be used to measure a nation's progress towards compliance with social, economic and cultural rights.¹ Clearly, compliance can only be judged against the yardstick of resources.

Restructuring of health services and the need to contain spiralling health costs have led many countries to focus on developing a basic health care package as a "right". The USA, in the Clinton era, had inconclusive discussions about this and basic packages have been implemented by governments as diverse as Brazil, Germany, Israel, and the Netherlands. As the BMA has discussed,² the prime responsibility for ensuring that rights are fulfilled rests with governments who are signatory to international human rights declarations. Nevertheless, hospitals and other health facilities may logically be deemed to have some obligations, by delegation from government, to respect the rights of people needing urgent treatment.

The question of what this right means to health professionals needs exploring. Access to health care, particularly in a life-threatening emergency, appears to be a fundamental component of any such postulated right. Also, individual health professionals are generally perceived as having an ethical duty to respond to "need" when they are able to help. In July 2001, the potential legal consequences of failing to do so were highlighted by a case in India where the

medical administrator of a Delhi hospital refused emergency treatment to an accident victim whose family were unable to pay. The Indian Medical Association pointed out that such cases were not unknown but the fact that the doctor was charged with "culpable homicide" made this an exceptional case which raises many questions.³

Euthanasia, assisted suicide and human rights

Assistance in dying at a time of one's own choosing is a staple topic of ethical debate. Over recent years, such discussion has become more urgent as the borderlines between legitimate and illegal options have increasingly blurred. The important moral and legal differences between non-treatment and intentionally hastening death has been examined by UK medical bodies, including the Royal College of Physicians,⁴ and recently the BMA updated its advice to incorporate the implications of human rights legislation.⁵ The General Medical Council is also preparing advice on this issue.

In many countries, health professionals are anxious to clarify the distinction between potentially accelerating death by aggressive symptom control in terminally ill patients and actively assisting suicide. In the UK courts, in 1996, Annie Lindsell, who had motor neurone disease, sought the right to control her death and to define the extent of permissible medical intervention. The court confirmed that doctors could administer treatment to relieve mental distress as well as physical pain, even if this accidentally hastened death. Her case was prior to the Human Rights Act 1998 and so it was predictable that the prohibition on assisting suicide would eventually be challenged by a patient whose disability precluded her from carrying out the act of suicide (which is not illegal) without assistance. In October 2001, Diane Pretty's case set

out to clarify patient rights in this context. Although Mrs Pretty was claiming a right to assistance from her husband, were she to win, the implications for health professionals were clear.

In July 2001, representatives of nine countries called on member states of the Council of Europe to re-examine euthanasia. They noted that recent Dutch legislation permitted euthanasia in certain circumstances and that similar legislation was in preparation in Belgium, in contrast with "the grey area of uncertainty" in which such procedures otherwise took place. They argued that legislation dispelled uncertainty by establishing clear criteria which health professionals had to observe in decision making and urged member states to develop "a convention clearly establishing the criteria according to which doctors who perform such medical acts (euthanasia) and the staff who assist them should be immune from prosecution".⁶

Male circumcision

One of the most difficult tasks the British Medical Association's (BMA) 2001 annual meeting asked the ethics committee to undertake was to "investigate the issues surrounding the circumcision of male children for whom there is no valid medical indication". In the UK there is considerable debate about this subject but no consensus has been achieved and nor are BMA members unanimous on how the matter should be handled; a significant minority believe that the BMA should not be handling it at all.

The big question for the committee will be how to identify the limits of what a medical association can usefully say about circumcision for religious, cultural, or social reasons. Giving ethical and legal advice about best practice in circumcision for medical reasons is relatively straightforward. The issues are the same as for other clinical procedures; procedures must be appropriate for the condition and conservative treatments are favoured over more invasive procedures

where this does not compromise effectiveness. Current guidelines stress these points.⁷

Circumcision for purposes other than therapy poses different questions. The BMA's advice is about how doctors should behave, although many circumcisions for religious purposes are done by non-doctors. The standard measures of "evidence based medicine" cannot be used where the benefits circumcision is claimed to bring are less tangible, including a sense of belonging to a religion, or fitting into a societal group. Its health impact is a legitimate area for comment by doctors, but it is not apparent that consideration of this will bring any clarification about whether circumcision is, as is traditionally argued, innocuous. Each side of the debate raises different issues; from low complication rates and protective qualities against HIV transmission, to risks of bleeding, scarring and infection at the time of the circumcision, and resulting lack of sensation in the penis.

Human rights arguments are also raised on both sides of the debate. Proponents of circumcision argue that religious freedom is violated if parents are denied the right to choose circumcision for their children. Groups opposed to circumcision argue that it is harmful and abusive, and breaches the child's right to be free from intrusion.

It will be difficult for the BMA to steer a middle path through the inevitably heated debate. The aim is to address the balance of benefits and harms, and to comment as far as a medical association can, and should, on these issues. Any further guidelines that result will be on the BMA's website.

Bristol report

The report of the Bristol Royal Infirmary (BRI) Inquiry into the management of the care of children receiving complex cardiac surgical services at the BRI was published in July 2001.⁸ The inquiry was charged with making recommendations to help to secure high-quality care across the National Health Service (NHS). The report concluded that the events at Bristol were not caused by "bad" people who did not care, or who deliberately harmed patients. Rather, those involved were dedicated and well motivated although some lacked insight and their behaviour was flawed. The report states that the health professionals were victims of a combination of circumstances which owed as much to

general failings in the NHS at the time as to individual failings.

The report's recommendations are numerous and far reaching, covering issues such as communication, consent, organisation, competence, training, revalidation, management, monitoring standards and performance, and public involvement in providing health services. The report made clear that improvements would require additional investment, pointing out that "nothing can be achieved 'on the cheap'".

The report has provided considerable food for thought for bodies such as the BMA, which has already begun the long process of analysis and encouraging and facilitating the practical changes necessary to make a real difference. Long before the final report was issued, medical bodies began action in response to the type of issues that were being raised. The BMA, for example, sent a *Consent Tool Kit*⁹ to over 70,000 doctors and a report on the teaching and practice of seeking consent¹⁰ to NHS medical and clinical directors. Other work has been ongoing and will continue to build on such initiatives.

Reports into practices in the NHS have been issued before, but there is a real sense in which this one will not, and cannot be allowed to, be forgotten. There is certainly the will to make things happen and the BMA hopes resources to make changes happen are forthcoming.

Regulating assisted reproduction in Canada

The Canadian Standing Committee on Health is due to report, in January 2002, on draft legislation on human assisted reproduction.¹¹ The proposals set out activities that should be regulated and proposes prohibitions on the following activities:

- Cloning humans (including "therapeutic cloning");
- Germline genetic alteration;
- Keeping an embryo outside a woman's body beyond 14 days;
- Creating embryos either from another embryo or fetus, or solely for research purposes;
- Transplanting reproductive material from animals into humans;
- Using human reproductive material previously transplanted into an animal;
- Sex selection (including by the sperm-sorting technique) except where there are medical indications;

- The sale and purchase of human embryos or gametes;
- Commercial surrogacy.

The committee proposes establishing a regulatory body to license people and organisations carrying out regulated activities, including research involving human embryos. This body will provide information about success rates, maintain a register of donors, recipients and people born from assisted reproduction, provide public information and advise ministers on policy developments. The objective is to protect the health and safety of those seeking assisted reproduction by, for example, limiting the number of embryos to be transferred or specifying the conditions under which human gametes or embryos can be stored. The draft legislation seeks to balance the privacy of donors and the wishes of children born following treatment by giving donors the option of whether to allow identifying information to be passed to their genetic offspring.

References

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- 2 British Medical Association. *The medical profession and human rights: handbook for a changing agenda*. London: Zed Books, 2001: ch 2.
- 3 Sharma DC. Indian doctor arrested for "culpable homicide". *Lancet* 2001;358: 306.
- 4 Royal College of Physicians. Medical treatment at the end of life. *Clinical Medicine* 2001;1:115-17.
- 5 British Medical Association. *Withholding and withdrawing life-prolonging medical treatment*. London: BMJ Books, 2001.
- 6 Motion for resolution presented by Mr Monfils and others to the Parliamentary Assembly of the Council of Europe. 4 Jul 2001. Doc 9170.
- 7 British Medical Association. *Circumcision of male infants*. London: BMA, 1996.
- 8 The Bristol Royal Infirmary Inquiry. *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Learning from Bristol*. London: The Stationery Office, 2001. (http://www.bristol-inquiry.org.uk/final_report/index.htm)
- 9 British Medical Association. *Consent tool kit*. London: BMA, 2001.
- 10 British Medical Association. *Report of the consent working party: incorporating consent toolkit*. London: BMA, 2001.
- 11 Health Canada. *Proposals for legislation governing assisted human reproduction: an overview*. Ottawa: Health Canada, 2001. (<http://www.hc-sc.gc.ca/english/reproduction/>)